A Tentative Plan

Intro and Overview

- Anxiety is a Big topic
- Resources – on website

What we will do today

- Why we get anxious
- What it looks like

What we will do today

- Main anxiety diagnoses-DSM-IV-TR
- Treatment approaches
- Exercises to demonstrate these
- Exercises to illustrate anxiety itself
- Want the day to be a pracitcal as possible

We have some clear learning objectives

1. Be able to recognise anxiety symptoms

2. Awareness of the functional impact of anxiety

3. Appreciation of aetiology

4. Be able to explain to patients the processes (cognitive, physiological and behavioural) associated with anxiety

Learning objectives

5. Know when to refer to specialist services

6. Know and practice the basic skills appropriate for primary health professionals where interventions are limited to 10-15 minutes and can continue over a long period.

Learning objectives

7. Understand the main psychological interventions so that patients can be Informed by the primary health clinical staff of what to expect from a specialist referral

8. Resources for clinicians – websites, written, tapes, workshops

9. Awareness of cultural issues and resource

Why are you here?

Outside story

- What do you want to get out of today?
- Write it down
- The inside story?

What is Anxiety?

- What are the signs of anxiety?
- The body sensations?
- Thoughts
- Emotions
- Behaviours

What is Anxiety?

The physiological signs of anxiety are not specific to anxiety!

This is important.

What is Anxiety?

We all know what it feels like.

High base rates in the community.

It co-occurs with a number of other disorders and problems

Sometimes indistinguishable from depression.

What is Anxiety?

Often called the common cold of psychology

Can cause extreme distress, and major impairment

Where does it come from?

Genetic ? Biochemical ?

Learned – Anx parent, violence, past abuse, volatile background or caregivers, move house, schools

Context – triggers: stress- illness, low mood, money or family problems old habits kick in

Often can be found in high achievers

Where does it come from?

In times of stress old habits of reacting kick in

Anxiety is generally characterized by physical sensations

But is determined by our judgments and evaluations of these.

Anxiety as a mental disorder is primarily a cognitive construct

- A thought Experiment

The Myth to Healthy Normality

- We bought the Medical Model*
- A return to homeostasis
- That Clients/Patients are broken

*It is perhaps unfair to refer to the mechaistic model as medical. The modern medical approach is much more Bio-Psycho-Social

Suffering

- Suffering is ubiquitous and normal
  - Suicide –
    - 50% struggle, mod-severe, =>2wks
    - nearly 100% contemplate it.
    - Animals don't !
  - How many people do you know who don't struggle?
    - (soc,wk,rel,anx,depr,ang,sc,sex,death)
  - Psych Disorder –
    - 33%+ at any one time
    - 50% over the life span
    - 80% of those who do, have more than one (Kessler 1994)
    - When open access → 50% mental disorder, 50%other probs
  - Life in general
    - Marriages (1 and 2) have ~50% failure
    - Fidelity, abuse, happiness stats → many intact but unhealthy (Previti&Amato 2004)

Anxiety Base Rates.

Prevalence In NZ in the past 12 months: Any disorder was 20.7%.

Anxiety disorders 14.8%,

mood disorders 7.9%,
substance use disorders 3.5%,
eating disorders 0.5%

The highest prevalences for individual disorders were for specific phobia (7.3%), major depressive disorder (5.7%) and social phobia (5.1%).

Only 31.7% of cases were classified as mild with 45.6% moderate and 22.7% serious.

Anxiety Base Rates.

Lifetime prevalence of any disorder was 39.5%.

Anxiety disorders, 24.9%;
mood disorders, 20.2%;
substance use disorders, 12.3%;
and eating disorders, 1.7%.

Prevalences for all disorders higher in the younger age groups.

Females higher prevalences of anxiety, mood and eating disorders males;

males had higher prevalences of substance use disorders.

Anxiety Base Rates.

The estimated projected lifetime risk of any disorder at age 75 years was 46.6%

The median age of onset -18 years.

So why are we, as a species so miserable?

- Experiential Avoidance
- Language
- Both of which lead to –
  - rule governed behaviour and
  - psychological inflexibility
  - Mind Bombs

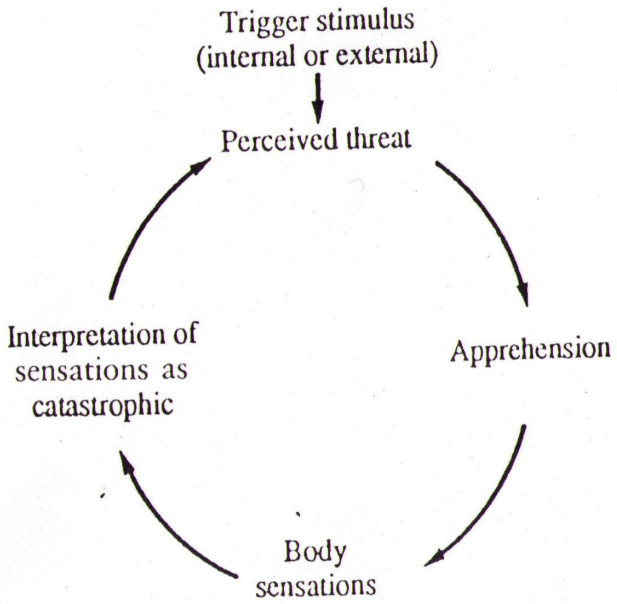


Fig. 3.1 The suggested sequence of events in a panic attack (reprinted with permission from Clark 1986*a*, p. 463)

We bought the Myth of Healthy Normality

- Language processes increase our suffering
- That these processes fuel avoidance as a coping strategy
- And that this often makes things worse

Talk a little bit about

How the mind works

Then move on to DSM and specific anxiety diagnoses

How you might deal with anxiety

Various therapies and how they work

“Every word began as a poem”

- “Each began as a picture”
- “It can’t surprise us that our language began with metaphors.”
- It is unfortunate that we learn words when we are so young as we take these strange symbols for granted.

Wilfred Funk, 1950

Lets look at language

By language I mean any system of symbols

- Pick a number

How is a . . .

(e.g. banana)	(e.g. more than a)	(e.g. candle)
1. banana	1. like	1. prostitute?
2. race car	2. unlike	2. war?
3. kangaroo	3. better than	3. chair?
4. foreman	4. different from	4. candle?
5. priest	5. worse than	5. house plant?
6. football	6. the father of	6. book?
7. hat	7. the cause of	7. mud hole?
8. computer	8. the partner of	8. baby?
9. TV	9. the opposite of	9. toilet?

Relational Frame Theory

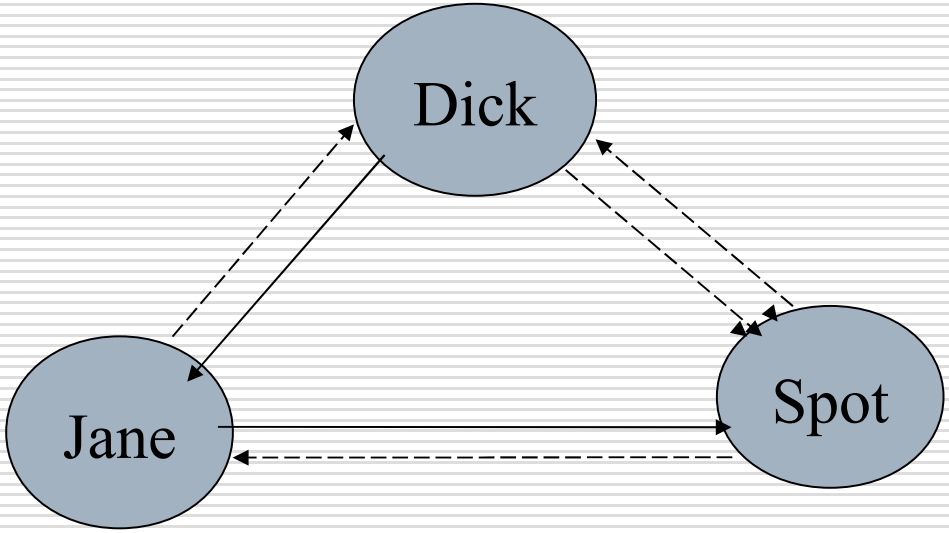
Words are an arbitrary set of symbols for things, actions, states ..

Language happens through the human ability to derive relations between symbols and the transformation of stimulus functions

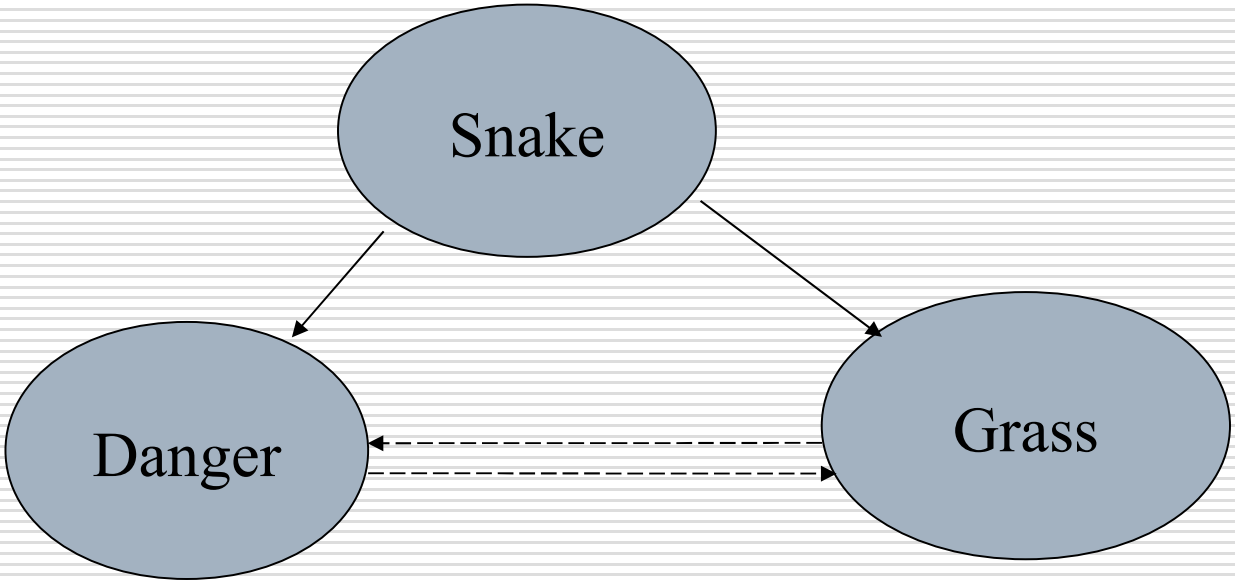
Relational Frame Theory

- Stimulus equivalence
- Derived stimulus relations
- Transformation of stimulus functions

Derived stimulus relations



Derived stimulus relations and the transformation of stimulus functions



Relational Frame Theory

$$C_{func}\ [C_{rel}\ A\ r_x\ B \text{ and } B\ r_y\ C\{Af^1 \mid\mid\mid Bf^2r_p \text{ and } Cf^3r_q\}]$$

Numerous Relationships

- **Coordination**
- **Hierarchical**
- **Opposition**
- **Deictic**
- **Comparison**
- **Distinction**

Because of these relationships

- You can't have good without . . .
- Happy without . . .
- We can't have life without. . .
- We can't "have" without . . .

This is the problem

- Each of these ideas (judgments -evaluations) has an emotional component
- We don't want to feel bad
- Therefore=> Emotional Avoidance (?)
- Often our efforts at control cause more problems than we started with

Thoughts are very powerful

- What has our experience taught us so far?

Transformation of stimulus functions

- When two stimuli are related, some of the functions of each stimuli change
- Taking on some of the stimulus functions of the other stimuli
- Stoves aren't just hot, they take on some of the characteristics of burn, danger, heat and so on

What does that mean for therapy and the problem of human suffering?

Language is the problem

Language allows unwanted events (distant, past, imagined) to be psychologically present

The dominance of language, and the psychological inflexibility it engenders tends to trap us within a limited range of responses to situations

Trying to rectify problems of language primarily through more language can lead to more problems

This isn’t just sick people

This is us!

Remember The Myth of Healthy Normality

Suffering is a central fact of human existence

- Suffering is normal
- Life often sucks

The Myth to Healthy Normality

- We bought the old medical model
- A return to homeostasis
- That Clients are broken

Relapse Prevention Type Model of Anxiety

Stress and Life Style Imbalance

→physiological arousal

→avoidance or worry/problem solving

→Stress + arousal also interpret this as catastrophic or bad

→Freak Out


EMOTIONAL
AVOIDANCE
DETOUR
nerg

Specific Anxiety Diagnoses

Anxiety disorders are more similar than different!

GAD, OCD, PTSD, Social Phobia, Panic . . and so on

What is your experience with working with anxious people?

What is Anxiety?

- What are the signs of anxiety?
- The body sensations?

DSM Diagnoses

Usually have a main general criteria, and lots of smaller ones

Must have - X, and two from list A, 3 from list C, not due to this or that

Main purpose – to give consistency to diagnoses

History?

GAD - and OCD as an example

Generalized Anxiety Disorder

Prototype Anxiety disorder

-Move from motor and autonomic symptoms to worry and anxious apprehension

- heightened negative affect – chronic overarousal -

-sense of unpredictability and uncontrollability

-attention focus on threat related stimuli

Content of apprehension varies in disorders

Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.

GAD

(1) restlessness or feeling keyed up or on edge
(2) being easily fatigued
(3) difficulty concentrating or mind going blank
(4) irritability
(5) muscle tension
(6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

GAD

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Diagnostic criteria for 300.3 Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems
(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

OCD

Compulsions as defined by (1) and (2):

(1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

OCD

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorders; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:
With Poor Insight: if, for most of the time during the current episode the person does not recognize that the obsessions and compulsions are excessive or unreasonable

Take Your Mind for A Walk

Contamination

Intrusive thoughts

Intrusive thoughts

Worry – excessive

Fear -

Failure- look stupid

Worry physical symptoms

Expert Consensus Opinion (website):– OCD as an example

Guideline 1: Selecting the Initial Treatment Strategy

1A. Treatment Choice by Severity of Illness and By Age

Summary : The experts usually prefer to begin the treatment of OCD patients with either CBT alone or with a combination of CBT and medication (CBT+SRI). The likelihood that medication will be included in the recommendation varies with the severity of the OCD and the age of the patient. In milder OCD, CBT alone is the initial choice. As severity increases, the experts are more likely to add medications to CBT as the initial treatment or to use medication alone. In younger patients, the experts are more likely to use CBT alone.

	Adult OCD	Adult OCD	Adolescent OCD	Adolescent OCD	Prepubertal OCD	Prepubertal OCD
	Milder*	More Severe*	Milder	More Severe	Milder	More Severe
Second line	CBT+SRI SRI first	CBT first	CBT + SRI SRI first	CBT first SRI first	CBT+SRI SRI first	CBT+SRI SRI first

*Mild OCD (Yale-Brown Obsessive-Compulsive Scale 10-18) causes distress but not necessarily dysfunction; help from others is usually not required to get through the day. Moderate OCD (YBOCS 18 -29) causes both distress and functional impairment. Severe OCD (YBOCS = 30 or above) causes serious functional impairment requiring significant help from others.

**CBT: cognitive-behavioral therapy

2A. Selecting a CBT Strategy (***bold italics*** = treatment of choice)	**Summary** : The experts consider the combination of exposure and response prevention as the optimal behavioral psychotherapy for OCD, while cognitive therapy may provide additional benefit by directly targeting distorted "OCD beliefs" and/or by improving compliance with E/RP.	
	Obsessions	**Compulsions**
First line	Exposure plus response prevention (E/RP) E/RP + Cognitive Therapy (CT)	***E/RP*** E/RP + CT
Second line	CT Exposure	Response Prevention CT Exposure

NOTE: Beware of expert "opinion." This information is wrong! There is no evidence that CT adds anything to CBT (Exposure and Response Prevention)

Treat all information on the web with caution!

No matter how reputable they are, or appear.

Experts can have vested interests

Experts can be wrong – they typically only read literature within their sphere/school of thought

Sponsors can definitely have vested interests

The case of Social Phobia!

Problematic Side Effect‡	Drug(s) Less Likely to Cause	Drug(s) More Likely to Cause
Cardiovascular	SSRIs	Clomipramine
Sedation	SSRIs	Clomipramine
Insomnia	Clomipramine	SSRIs
Anticholinergic	SSRIs	Clomipramine
Weight gain	SSRIs	Clomipramine
Sexual	SSRIs (but still common)	Clomipramine
Akathisia	Clomipramine	SSRIs
Nausea/Diarrhea	Clomipramine	SSRIs

Interesting, useful, but should not take the place of medical opinion, or practice guidelines laid down by our own professional boides

Other common diagnoses

GAD

SAD

Agoraphobia

Panic Disorder

Phobias

PTSD

Requires a serious traumatic event

The only DSM disorder that requires a causal link to an external cause

Has been described as the only psychiatric disorder that people want to have.

Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that,
in the past month, you…

1. Have had nightmares about it or thought about it when you did not want to?

YES NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

YES NO

3. Were constantly on guard, watchful, or easily startled?

YES NO

4. Felt numb or detached from others, activities, or your surroundings?

YES NO

Working with the anxious client

Most important – Remain Calm

Normalize

Bring them back to the moment – grounding exercises

Give clear – simple instructions

Give them something to do, or to work on

Sleep is important

Check for other health issues

Working with the anxious client

Breathing exercises

Progressive Muscle Relaxation

Coping strategies -

Calming self statements

Exercise- keep it simple

Time out

Grounding- distraction exercises

When to refer on

Problems are extreme – significant impact on functioning,- family, job, getting in the way of things

Problems are prolonged, persistent, distressing, or deterioration

Co-morbidity – multiple problems: diagnoses, health issues, family/social problems, stressors

Poor coping skills or little social support

Young people – if can help with the problem early can save a lot of hardship and harache

When to refer on

When there is evidence of risk - self harm, suicide

Thoughts, plans, past attempts, substance use, past diagnosis of personality disorder, male, young, old

*How effective would suicide be in solving their problems,

and *Willingness to tolerate their distress

See handout – Chiles and Stroshal 2005

These are really your areas of assessment

In addition to a problem description, a diagnosis

Look for strengths

Length of time of problem

Is it waxing and waning, does it come and to in relation to triggers

Risk factors

Treatment

CBT – Cognitive Behavioural Therapy

An eclectic psychotherapy in the cognitive-behavioural tradition

This is the scientist-practitioner tradition

A bit of history

Werner Lightner - Boulder Model – Behavioural therapy – development of CBT – the capture of the phrase “CBT”

Treatment

All CBT therapies rely heavily on Exposure, Response Prevention, Behavioural Experiments, attending to emotions and cognitions. Most look at the development of Coping Skills.

Exposure and Response Prevention are often used in conjunction. Response prevention is very rarely used alone, particularly with adult populations. Both these practices are more purely Behavioural, however are generally utilized within a CBT framework.

All of the common therapies I will describe are CBT therapies.

Treatment

Exposure – Prolonged contact with the feared object generally results in a reduction in fear, anxiety and distress. This is called habituation. Graded exposure if generally used.

Response Prevention – Simply preventing the usual response which is used to deal with the fear. This helps change old automatic habits of reacting, and helps develop new ones, in conjunction with habituation.

Coping skills – learning new, or strengthening existing skills. Relaxation training, cognitive restructuring, breathing techniques, social skills training, problem solving training, behavioural rehearsal can all be seen as the development of coping skills.

Treatment

Cognitive Therapy- there are several cognitive therapies. The central component of most cognitive therapies is changing thoughts. The idea is that changing maladaptive or unhelpful thinking will change emotional reactions, and behaviour.

ACT (pronounced act) Acceptance and Commitment Therapy– a modern variant of CBT. Different philosophical basis – a contextual therapy. Based on a coherent theory of language and cognition (RFT). Pays attention to thoughts but does not try to actively change them, or to remove distressing experiences. Looks at increasing meaningful behaviour

Treatment

DBT – Originally developed for use with suicide and borderline personality. Heavy reliance on skill training for distress tolerance. Also employs mindfulness and other approaches.

Meta-Cognitive Therapy – A cognitive model. An expansion of traditional CBT taking a meta cognitive approach. Does contain other behavioural and cognitive approaches within its therapy.

Behavioural Activation – A contextual therapy (like ACT). Has an emphasis on the context of the problems, and on behaviour. Originally developed for use in depression, now being expanded. Can be used alongside other treatments or therapies

Treatment

IPT (Interpersonal Therapy) – Originally developed for those experiencing depression, Now being developed for use in several areas. Focuses on interpersonal relationships as the prime target of therapy.

MCBT (Mindfulness Based Cognitive Therapy) – Really a CBT with an emphasis on mindfulness. This was initially developed for recurrent depression. Good scientific rationale and evidence for use in recurrent depression. Is now being used with a wider range of problems.

Treatment

Mindfulness integrated Cognitive Behavioural Therapy (MiCBT)– One of the purer forms of mindfulness based therapies. Involves a heavy reliance on mindfulness training, exposure techniques, and naturalistic behaviour techniques (doing things)

Mindfulness Based Therapies. - those therapies which use mindfulness practices as part of the therapy. There is a good rationale for mindfulness as a therapeutic tool. There is also a growing number of treatment studies which include mindfulness as a component of treatment. Those studies which have looked at the active processes in therapy find that mindfulness targets important active processes that contribute to outcome in therapy – such as acceptance, the de-literalising of language.

Treatment

Of the mindfulness based therapies only MiCBT and ACT use mindfulness in a way fully consistent with its practice. That is, the theoretical use of mindfulness is not confounded with a cognitive-change strategy. DBT and MCBT also rely heavily on mindfulness practices, however as a core component of treatment use practices designed to alter the current experience of the client or patient.

Cultural Issues

Some Resources:

I have set up a wiki educator page and will post a number of links and other resources there. I will also try to put up mp3s of some of the exercises we did today so they can be downloaded. The link is

- http://wikieducator.org/Psychology_professional_development

I do worry about people seeing items on the internet and thinking that they will be the answer to their problems. This is never the case. Good resources can be had through the local library, or by inter-loaning books through the library. Although I may have posted a link beware if it is trying to sell something

A good book (not on anxiety) is

Assessment and treatment of suicidal Patients

Chiles, and Strosahl, 2005

Books : These are only useful if read carefully, and the exercises followed consistently for a period of time.

- **Get Out of Your Mind and In to Your Life: The new Acceptance and Commitment Therapy**

  By Steven C Hayes PhD, Publisher New Harbinger

- **Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness –** 15th Anniversary Edition

  By Jon Kabat-Zinn

- **Waking up to What You Do**

  By Diane Eshin Rizzetto, Publisher Shambhala

More Suggested Reading

The best books are those that speak to you. There are many good books on skills, and that have numerous exercises/techniques. The best seem to often be published by New Harbinger. Such as the Stress Reduction Workbook.

Stress Management by Charlesworth and Nathan is a very good book on stress – has the best PMR script in it (Interloan?)

Other good books useful for work with anxiety, but not specific to it are

- **'Get out of your mind and into your life: the new Acceptance and Commitment Therapy,' Steven Hayes, New Harbinger publications, 2005.**
- **'Acceptance and Commitment Therapy: An Experiential Approach to Behaviourr Change , Steven Hayes, Kirk Strosahl, Kelly Wilson, Guilford Press, 2004.**
- **Depression in Context: Strategies for guided action. Martell, Addis, and Jacobson. Mainly depression, but can be useful for anxiety**

More Suggested Reading

Behavioral Consultation and Primary Care: A guide to integrating Services. (2007). Robinson, P J, and Reiter, J T. Springer.

A good general book for primary health care consultations-includes some information mental health issues

Acknowledgments

- Steve Hayes, for slides and information
- Eric Fox, whom I believe created the RFT tutorial on the contextualpsychology.org website, which along with the 2001 RFT book inspired the RFT diagrams I used
- Unless otherwise stated the cartoons come from Joe Ciarrochi and his colleagues at the University of Wollongong the citation is

Ciarrochi, J. & Mercer, D. (2005). Images for conducting Acceptance and Commitment Therapy Interventions (part 1). University of Wollongong, Australia.